PEPFAR Ethiopia In-Country Reporting System (IRS)
Reporting Template

Ethiopia Community Prevention of Mother-to-Child Transmission Project (CPMTCT)

IntraHealth International, Inc.

PROGRESS REPORT FOR

FY2010

ANNUAL PROGRAM RESULTS (APR)
(OCT 2009 - SEPT 2010)

CONTACT INFO FOR THIS REPORT:

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LIST OF ACRONYMS

AARHB	Addis Ababa Regional Health Bureau
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavioral Change and Communication
BEMOC	Basic Emergency Obstetric Care
CBO	Community-Based Organization
CMSG	Community Mothers Support Group
CSO	Civil Society Organization
DCCM	Demand Creation Community Mobilization
EOC-DICAC	Ethiopian Orthodox Church Development and Inter Church Aid Commission
FMOH	Federal Ministry of Health
FP	Family Planning
GF	Global Fund
GOE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HC	Health Center
HCSP	HIV AIDS Care and Support Program
HEP	Health Extension Program
HEW	Health Extension Worker
HMIS	Health Management Information System
IEC	Information, Education, and Communication
IFHP	Integrated Family Health Project
IYCNP	Infant & Young Child Nutrition Project
IOCC	International Orthodox Christian Charities
MNCH	Maternal, Neonatal and Child Health
MOU	Memorandum of Understanding
M&E	Monitoring and Evaluation
MSG	Mother Support Group
NVP	Nevirapine
PATH	Program for Appropriate Technology in Health
PFSA	Pharmaceutical Fund and Supply Agency
PHCU	Primary Health Care Unit
PI	Performance Improvement
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission
RFA	Request for application
RHB	Regional Health Bureau
SCM	Supply Chain Management
SS	Supportive Supervision
TOT	Training of Trainers
TWG	Technical Working Group
VCHW	Volunteer Community Health Worker
VCT	Voluntary Counseling and Testing
UHEP	Urban Health Extension Program
UHEW	Urban Health Extension Worker
UHPDP	Urban Health Promotion and Disease Prevention
UNICEF	United Nations Children's Fund
WrHO	Woreda Health Office

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1. Reporting period

From	To
October 1, 2009	September 30, 2010

2. Publications/reports

Did your organization support the production of publications, reports, guidelines or assessments during the reporting period?

No/Not Applicable ☒
Yes ☐ If yes, please list below:

Publications/Reports/Assessments/Curriculums

Title	Author	Date

If Yes, Please attach an electronic copy of each document as part of your submission.

3. Technical assistance

Did your organization utilize short-term technical assistance during the reporting period?

No/Not Applicable ☐
Yes ☒ Please list below:

Consultants/TDYers

Name	Arrival	Departure	Organization	Type of Technical assistance provided
Kate Stratten	Oct 19, 2009 Sept 26, 2010	Nov 13, 2009 Oct 13, 2010	IntraHealth International	Project start-up Annual review and year two work planning
Marsha Hamilton	Oct 19, 2009 Sept 20, 2010	Nov 6, 2009 Oct 6, 2010	IntraHealth	Project start-up Annual review and year two work planning
Catherine Murphy	April 2010	April 2010	IntraHealth	Learning for Performance training
Dr. Joseph Petralgia	June 12, 2010	June 29, 2010	Pathfinder	Support training of trainers (TOT) on community mobilization training
Rae Galloway	Dec 7, 2009 April 24, 2010 Sept 29, 2010	Dec 18, 2009 May 7, 2010 Oct 8, 2010	PATH (Program for Appropriate Technology in Health) International	Project start-up and staff orientation Infant feeding assessment in Tigray and Addis Ababa Annual review meeting and year two planning
Jennifer Marcy	Dec 11, 2009	Dec 18, 2009	PATH International	Project start-up, staff orientation and work planning
Laura Gibney	Jan 23, 2010	Feb 18, 2010	IntraHealth	Performance Monitoring Plan (PMP), monitoring and evaluation (M&E) tools and plan

If Yes, please attach an electronic copy of the TA report as part of your submission.

4. Travel and Visits (only project-funded)

Did your organization support international travel during the reporting period?

No/Not Applicable ☐
Yes ☒ Please list below:
International Travel (All international travel to conference, workshops, trainings, HQ or meetings).

Name	Destination	Departure from Ethiopia	Arrival	Host Organization	Purpose of the travel
Addis Kassahun	Chapel Hill	Aug 19, 2010	Sept 3, 2010	IntraHealth	Planning for project transition workshop
Semegnew Mengistu	Chapel Hill	Aug 19, 2010	Sept 3, 2010	IntraHealth	Planning for project transition workshop
Patricia McLaughlin	Chapel Hll and Florida	Aug 7, 2010	Sept 3, 2010	IntraHealth	Home leave and planning for transition workshop
Yetimwork Tekle	Kenya	May 24, 2010	May 29, 2010	USAID Kenya IH Kenya supported inland transportation	Family planning (FP) integration in MNCH/PMTCT/ART services

Have any monitoring visits/supervision been made to your program in during the reporting period?

Description of Monitoring team	Start date	End date	Sites visited	Written recommendations provided
Yoseph Woldegebriel and Peter Gichanji	July 29, 2010	July 29, 2010	Neksege and Meswaeti health centers (HCs), Tigray	Verbal recommendation
Yoseph Woldegebriel and Peter Gichanji	July 9, 2010	July 9, 2010	Saris HC, Addis Ababa	Verbal recommendations provided
Yoseph Woldegebriel and Peter Gichanji	July 26, 2010	July 26, 2010	Kombolcha and Geriro sites, Amhara	Verbal recommendation on referral linkage
Yoseph Woldegebriel and Tesfaye Wolde	July 22, 2010	July 22, 2010	Alem bank HC , Addis Ababa	Verbal recommendation on referral linkage

5. Activity

Program Area (Tick all which apply)	Activity ID	Activity Title (Please write the title of the activity)
☐ 01-PMTCT	28789.09	Development and expansion of community-based PMTCT
☐ 02-HVAB		
☐ 03-HVOP		
☐ 04-HMBL		
☐ 05-HMIN		
☐ 07-CIRC		
☐ 08-HBHC		
☐ 09-HTXS		
☐ 10-HVTB		
☐ 11-HKID		
☐ 12-HVCT		
☐ 13-PDTX		
☐ 14-PDCS		
☐ 15-HTXD		
☐ 16-HLAB		
☐ 17-HVSI		
☐ 18-OHSS		

6. Accomplishments and successes during the reporting period

IntraHealth was awarded the Community Prevention of Mother-to-Child Transmission (CPMTCT) Project on September 30, 2009.

The focus in quarter one was on project start-up. This included office procurement and set-up; recruitment and training of staff; procurement of furniture and equipment; signing official sub-awards with partners as well as site selection in conjunction with the Regional Health Bureau (RHB) and partners. Due to the timing of the Urban Health Extension Program (UHEP) graduation, project staff rapidly prepared a three-day course on MNCH/PMTCT, which included reinforcement of behavioral change communication (BCC) and referral knowledge. IntraHealth also participated in designing the Safe Motherhood/PMTCT month during this period, initiated support at the HC-level in Amhara, and assisted the Addis Ababa Regional Health Bureau (AARHB) to train community mothers support group (CMSG) mentor mother-community focal persons, leveraging funds they would receive from the Global Fund for this end. IntraHealth also assisted HIV AIDS Care and Support Program (HCSP) to train site coordinators and mentor mothers in Amhara and SNNP.

The emphasis in quarter two included finalizing the USAID year one workplan and PMP; signing memorandums of understanding (MOUs) and finalizing year one workplan/project sites with RHBs; finalizing project supervision and monitoring tools; initiating baseline data collection; and supporting and developing trainings for key cadres of health workers. Supportive supervision to new HC sites began at this time, as well as the community sensitization workshops, mapping of community resources, and full participation in the Community-MNCH and Quality Management Technical Working Group (TWG). More than 2,000 Urban Health Extension Professionals (UHEPs) were trained in MNCH/PMTCT this quarter using the three-day course prepared in the previous quarter. Supply issues were brought to the attention of the RHB and USAID. At the request of the Urban Health Promotion and Disease Prevention Directorate, IntraHealth agreed to provide a consultant to assist the directorate in micro-planning and building the directorate staff knowledge and skills in PMTCT.

Quarter three emphasis was on performance improvement (PI) and supportive supervision (SS) TOT; training health providers in new sites; initiating the training of Ethiopian Orthodox Church spiritual fathers and lay volunteers; and participating on groups trying to harmonize information, education, and communication (IEC)/BCC messages. The supply issue (shortage or test kits and antiretroviral [ARV] drugs in particular) became critical in this period, and after meetings with USAID and Supply Chain Management (SCM), IntraHealth-supported HCs as well as new Integrated Family Health Project (IFHP)-supported HCs were included on the national SCM procurement list for upcoming procurements. IntraHealth sought and received permission to purchase basic infection prevention materials for new HCs in project woredas. In addition, as part of the MNCH/PMTCT TWG, IntraHealth participated in an initial revision of the national PMTCT training materials and provided PMTCT training for Federal Ministry of Health (FMOH) UHPDP case teams. Also, in conjunction with the FMOH, IntraHealth hired a firm to finalize the revision of the national MNCH/PMTCT training materials. The CPMTCT Project also trained over 100 Addis

Ababa sub-city family health and UHEP officers and health office heads in a tailored PMTCT training for managers. The training focused on the technical components of PMTCT—clinical, community, MSG; on management basics, especially use of health management information system (HMIS) data for decision-making; and the trainees' role in ensuring the quality of the various components.

Quarter four emphasis was on reviewing consultant drafts of the MNCH/PMTCT training materials, outreach, and the training and deploying of health extension workers (HEWs)/volunteer community health workers (VCHWs), including women's association members, to begin referring clients to the HC level. The referral system has begun to work in many sites; however, in the move from a system of one HC based in the woreda town to three to four HC per woreda—and given the emphasis on urban sites where health facilities may be numerous—a more thorough orientation of all stakeholders (HC staff and hospital staff, managers, kebele and woreda health officials) on the project referral system arose as a critical need. In addition, PI and SS TOT continued and roll-out of the cascade training began with a view to ensuring that HC managers and staff, as well as woreda health office heads, were well-versed in PI and SS, as self-assessment is a key strategy to improving quality. We also assisted AARHB in evaluating its Global Fund (GF) CMSG expansion intervention and agreed to IntraHealth's support for the coming year.

Project Management:

Project Advisory Team: This team—composed of Pathfinder, International Orthodox Christian Charities (IOCC) and PATH country representatives, seconded advisors and the CPMTCT director and deputy director—met three times as an advisory team. In addition, the project advisory team members participated in the CPMTCT review and planning meeting. Issues discussed and resolved at the advisory team meetings included coordinating salaries, benefits and per diems, including per diems paid to health sector staff members when they are trainees and when they are trainers.

Project Management Team: This team consists of CPMTCT central office managers, advisors and regional managers. It met quarterly to review progress and plan the next quarter's activities.

M&E: In addition to preparing the project PMP and Country Operational Plan 2010 and 2011 targets, the M&E team drafted the M&E operational plan, and with other staff, developed the project monitoring tools including:

- Monthly data collection forms (for all program components)
- Tracking forms (outreach, technical assistance, workshops)
- Supportive supervision checklists
- Demand Creation Community Mobilization referral cards (Amharic, Oromiffa, Tigrigna)
- Registers (DCCM activities register, CMSG follow-up register, revise MSG register

Regional M&E officers and other regional staff were trained in the M&E system, and regional databases were set up. A complete listing of CPMTCT intervention woredas and health centers has been updated and the list of CD4 testing sites for expansion HC has been finalized.

Baseline data was collected and analyzed, and the final report is pending review from Chapel Hill.

As members of the management team, M&E staff also produced quarterly progress reports for the review meetings as well as produced quarterly, semi-annual, and annual PEPFAR reports. Information about infrastructure needs at expansion sites was shared with the FMOH and UNICEF WASH program.

Objective 1: To build the capacity of regional health bureaus, zonal and woreda health offices, and community-based organizations (CBOs) to support and manage community-based PMTCT services

The emphasis on capacity building in year one resulted in assisting the FMOH to develop a safe motherhood/PMTCT plan; contributing to the revision of existing national PMTCT training materials; producing new MNCH/PMTCT training materials for the health extension program; building regional capacity in HMIS; and providing technical and financial assistance for key review meeting at various levels. The project also monitored the supply situation on the ground through supportive supervision and used a two-track approach of assisting the RHB to inform Pharmaceutical Fund and Supply Agency (PFSA) of the situation as well as directly informing both USAID and the FMOH.

FMOH-level
The CPMTCT Project is represented on the Safe Motherhood-PMTCT, Community-MNCH, Nutrition and Quality Management TWGs, which serve as a forum for technical assistance to the FMOH.

As part of the ***Safe Motherhood/PMTCT TWG***, the CPMTCT Project participated in and presented promising practices at the FMOH-led national safe motherhood/PMTCT micro-planning and the Federal HAPCO-led meeting on increasing religious leader involvement in PMTCT; supported the month-long safe motherhood/PMTCT campaign, including producing and airing PMTCT-related radio spots; and participated in the Bush Institute-facilitated meeting with Safe Motherhood/PMTCT TWG partners. One outcome of the micro- planning was the FMOH interest in promoting a "fast-track" approach to improving PMTCT performance, which in many ways was similar to the CPMTCT Project's community demand creation intervention. However, to eliminate any payments to volunteers, the FMOH opted to use women's associations to promote safe motherhood/PMTCT. Currently Dr. Tadesse, the CPMTCT-funded consultant seconded to the FMOH UHPDP directorate, has been tasked with developing the training curricula for the women's associations. IntraHealth, like other TWG partners, has provided CPMTCT training materials, as well as cost information about community interventions for FMOH's submission to the Global Fund. In the meantime, the CPMTCT Project is training women's associations with the CPMTCT HEW/VCHW material, and women's associations are participating in the referral mechanisms.

Another key achievement of the safe motherhood month, resulting from frequent and detailed raising of the issue in many forums, was the (re)proclamation by national and regional parliaments of the fee exemption for maternal health services to explicitly include all drugs, labs, supplies, and services.

CPMTCT Project staff also contributed to the Ambo meeting to revise the national PMTCT training materials. In conjunction with the FMOH, the project hired a local consulting firm to complete the revision, and IntraHealth staff in Chapel Hill—as well as CPMTCT staff—provided detailed comments on the initial drafts. The FMOH asked that the CPMTCT Project include its materials for the three-day pre-placement training for the UHEP as part of the overall national training materials revision.

In a joint effort between the ***Nutrition*** and Safe Motherhood PMTCT TWGs, the CPMTCT staff is involved in the effort, led by John Hopkins University -Tsehai, to update infant feeding training for health providers and MSG mentor mothers. The project also participated in the review of infant feeding counseling cards (a job aid for health providers) and is a member of the group looking at updating the World Health Organization guidance on infant feeding for the Ethiopia situation. Furthermore, CPMTCT together with FMOH, UNICEF, Alive and Thrive, and IYCN supported for the World Breast Feeding Week celebration at national and regional levels.

As part of the ***C-MNCH TWG***, the CPMTCT Project shared training and IEC materials with the TWG interested in standardizing community-level training and harmonizing MNCH messages.

RHB/Regional HAPCO level
In addition to providing technical and financial support to the rollout of the safe motherhood events at the regional level, the CPMTCT Project supported biannual review meetings, usually forming part of the partner RHB/RHAPCO group setting the agenda. A key achievement in a recent review meeting in Eastern Amhara was the recognition that it would be more effective to have review meetings at lower levels (zones, woredas and kebeles) and limit regional meeting participation. The project also supported zonal MNCH/PMTCT review meetings with other MNCH/HIV partners following joint supportive supervision visits and began strengthening the "network" kebele meetings to support UHEPs in their jobs in Oromiya and SNNP.

The CPMTCT Project supported the rollout of the HMIS in the regions/zones we work in. This included funding HMIS TOT for 179 staff in SNNP and Tigray, and technically and financially supporting basic HMIS training for 75 woreda and health center staff in Amhara region.

In terms of logistics management, no specific trainings were provided this year. Instead CPMTCT staff monitored the supply situation and encouraged regions to include new HCs in their official requests to PFSA; CPMTCT staff followed this up with partners at the national level. Through participation in the USAID-led PMTCT procurement meeting (where MNCH equipment and supplies needed for hospitals and health centers are identified), the CPMTCT Project ensured that all new CPMTCT and IFHP PMTCT health centers were included on the SCM/PFSA procurement/distribution lists. Subsequently regional project staff worked with RHB and local offices of PFSA/SCM to ensure that all the regions that proposed PMTCT

expansion sites were included for future procurements. The issues surrounding the supply of Rapid Test kits and ARV drugs are not yet completely resolved but seem to include communication between RHB and PFSA, distribution and timely reporting of usage as the system is still push-driven.

Civil Society Organization (CSO): The CPMTCT Project identified two strategies for building CSO capacity. One is IOCC sub-granting and mentoring of the Ethiopian Orthodox Church Development and Inter Church Aid Commission (EOC-DICAC) to undertake PMTCT activities in the project area. The other is the completion of organizational capacity assessments of 20 CSOs identified as potential partners in demand creation and/or as ongoing support for MSG groups. These CSOs are primarily people living with HIV/AIDS associations. The project also trained trainers in EOC-DICAC and women's associations, described more thoroughly in objective 3.

Table 1: Actual performance vs. planned target for activities under objective 1

Indicator #	Performance Indicator		Actual	Target	Accomplishment (%)	Reason for variations
1.1 - 1	# of CBOs provided with technical assistance for community PMTCT program management		20	20	100	
1.1 -2	# of RHBs and woredas provided with technical assistance for community PMTCT management	RHB	5	5	100	The town and surrounding Kebeles counted as one woreda during planning were found to have two separate administrations: town and rural.
		Woredas	127	95	133.7	
1.2 - 1	# of national technical forums on MNCH/PMTCT best or promising practices		1	1	100	
1.2 - 2	# of MNCH/PMTCT guidelines, job aides and other tools developed/revised and implemented		3	3	100	
1.2 - 3	# of trainings in integrated MNCH/PMTCT for health providers and their supervisors		11	10	110	
1.2 - 4	# of health providers/ supervisors who successfully completed training or refresher training in integrated MNCH/PMTCT		574	420	136.7	IntraHealth provided training for some staff from "indirectly supported health centers", i.e. new health centers in target woredas that no other partner was supporting.
1.3 - 1	# of logistics management skills workshops for woreda, HC, health post, and region		0	6	0	FMOH and the AARHB preferred we focus on training of managers in PMTCT technical components (MSG, community, clinical), PI and SS and use of information for decision-making. Over 100 FMOH case team members and AA sub-city managers and supervisors attended these trainings.
1.3 - 2	# of Government of Ethiopia (GOE) personnel at logistics management skills workshop		0	90	0	
1.4 - 1	# of CBOs and woredas (or sub-cities) provided with technical assistance in financial management or financial procurement	CBOs	0	20	0	
		Woredas (or sub-cities)	0	10	0	
1.4 - 2	# of individuals trained in financial management		0	55	0	
1.5 - 1	# of MNCH/PMTCT TWG recommendations that have been adopted by the GOE		0	1	0	
1.5 - 2	# of MNCH/PMTCT policies passed/amended that are consistent with CPMTCT advocacy		1	1	100	
1.5 - 3	# of National public presentations highlighting service delivery successes or problems and proposing replication or change for solution		2	2	100	
1.6 - 2	# of public health sector staff trained in HMIS and use of HMIS data for quality improvement and decision-making		254	400	63.5	Delay in the HMIS rollout in Amhara, Oromiya and AA because of preconditions such as lack of shelves and of information technology personnel at HCs.

Objective 2: To increase access to MNCH/PMTCT services through providing facility and community services

and improving bi-directional linkages/referrals between MNCH/PMTCT services at the community, health post, health center and hospital level

This year the CPMTCT Project approach to increasing access included:

a) Assisting the RHB to expand PMTCT to new HCs, both directly through our proven performance improvement methodology that provides intensive (monthly) supervision initially, then less frequent supervision as quality of services improves, and trying out "indirect" support where IntraHealth provided some job aids and shared training costs but the RHB was to provide the supportive supervision directly
b) UHEP supervisors and UHEPs training to ensure they offer house-to-house counseling and testing of pregnant women and partners (if positive test the rest of household); as well as referral of pregnant mothers for focused antenatal care (split task, some services provided by UHEPs, others by HC staff), provision of postnatal care at the household level, and follow-up of all HIV Exposed Infants and mothers in their 500-household catchment areas
c) Outreach services from woreda/HC level to health posts
d) Assisting RHB and partners to expand MSGs; piloting CMSGs in AA in conjunction with AARHB
e) Referral tools, community mapping, monthly primary health care unit and quarterly woreda or sub-city meetings to review referrals from UHEPs/HEWs/VCHWs
f) Drafting a protocol to pilot transport allowances for health extension program supervisors.

a) Expansion to new HC

IntraHealth assisted the RHB to expand PMTCT services to 48 HCs using the "direct" methodology and supported them to expand services to another 95 new HCs using a less intensive support strategy: "indirect" sites. The idea was that the CPMTCT Project would model how to expand PMTCT services (clinical and community) in one HC catchment area, assist the woreda with some training and job aids to the indirect sites, train woreda health officials and both direct and indirect HC managers in PI and SS, and then the woreda would expand to the new sites. While the project could participate in some joint SS at the sites, we would not provide follow-up mentoring. This did not work precisely as planned.

A large number of HCs began offering services this year, and all should have had the minimal supplies necessary to offer PMTCT services as part of focused antenatal care. However, even the HCs selected for direct expansion were not ready to offer full PMTCT services when the project began, making it impossible to model PMTCT services appropriately. The PEPFAR definition of a facility offering PMTCT services is a facility offering HIV testing and counseling as well as ARV prophylaxis. In fact, the number of direct expansion HCs offering PMTCT service by the end of each quarter was 1; 17; 46; and finally, by the end of quarter four, 48 HCs offered PMTCT services.

The expansion HCs are located in what were thought to be high-prevalence woredas as well as in less high-prevalence woredas. Performance in the direct expansion HCs improved rapidly in terms of client load and percentage of those tested who came in for antenatal care, reaching an average of 87.7% of antenatal care clients tested and counseled, in spite of supply issues. ARV prophylaxis uptake was slower, partly due to the fact that many HCs only began providing ARV in quarter three, and partly due to the fact that some patients were not yet at 28 weeks. Project data shows that at expansion HCs most HIV-positive mothers who received prophylaxis delivered at the facility (74%) and got ARV; however, only 37% of the HIV-positive mothers identified at the expansion sites received ARV at the expansion sites (since many didn't offer services until late in quarter three). Please see the following for performance by HC directly and indirectly supported by IHI.

Table 2: Comparative analysis of HCs on selected MNCH/PMTCT indicators(third quarter)

Coverage indicators	Category of health centers	
	Expansion (48HCs)	Indirect (65 HCs)*
Antenatal care clients received HIV test results (# & %)	3644(87.7%)	4440(55.8%)
HIV-positive prevalence (# & %)	65(1.8%)	55(1.2%)
HIV-positive pregnant women who received ARV prophylaxis (# & %)	24(36.9%)	17(30.9%)
Male partners tested (# & %)	977(26.7%)	211(4.8%)

*It is only 65 of the 95 indirect HCs for which data is complete.

Access to infection prevention, rapid test kits, and ARV drugs were key limitations to the rapid expansion of PMTCT services.

After consultation with USAID, the FMOH, the RHB and SCM, IntraHealth received permission to procure basic infection prevention materials for both direct and indirect expansion centers in our project woredas; and worked with the regions, zones, and woredas to arrange sharing of supplies from the antiretroviral therapy (ART) HCs to the new PMTCT HCs and/or shift supplies from some zonal HCs—where supplies were in excess—to the new HC.s

Going forward, IntraHealth will agree on explicit expansion strategies in each region and with each woreda as it may be that the regions can support more of the training costs while IntraHealth assumes more responsibility for supportive supervision.

b) UHEP rollout

The rollout of the ***UHEP program*** has been met with numerous challenges. In quarter one and two, the project rushed to prepare PMTCT training materials to ensure that PMTCT was included in the UHEP pre-placement training. The project trained 2,550 UHEPs in MNCH/PMTCT and BCC basics, as well as on the role of the UHEP in referral and follow-up. However, the UHEPs completed their training before their supervisors and before town and kebele officials and leaders were oriented and informed of UHEPs role in their communities. As a result, deployment was disorganized and supplies sadly lacking. In addition, baseline data collection occupied the first several months of the UHEP's work, which took far longer than had been anticipated for the reasons mentioned above. The lack of HIV test kit supplies also meant that the UHEPs only began testing in a few sites in Amhara and Tigray by the end of the project's first year.

When the UHEP project was designed, UHEPs were to be attached to specific HCs; however, in reality, some regions chose to attach UHEPs to the kebele health offices (Oromiya, AA) while others chose to attach them to a HC (Tigray, Amhara, SNNP). The latter is essential for referral to work well, so IntraHealth is working closely with the RHBs and the UHEP TWG at the regional level to ensure HC attachment. The attachment to kebele health offices has had some implications for those who provide supervision. In AA, many kebele UHEP supervisors are nurses, but in Oromiya the majority are environmental and sanitation degree-holders. Although environmental sanitation and hygiene are key components of UHEP work, another strategy is then needed to provide MNCH/PMTCT technical supervision. If UHEPs are attached to the HC, clinical staff can offer this support.

Overall, the CPMTCT Project assisted in the training of 2,550 UHEPs and 171 UHEP supervisors in this project year. Only in the last two months have UHEPs in some regions begun referring clients for HC services, and as mentioned above, in a few towns house-to-house counseling and testing has begun. Strengthening the referral and follow-up linkage will be the emphasis of the program in year two.

c) *Outreach*

The program planned systematic integrated MNCH/PMTCT outreach in 40 woredas. In 11 woredas in Tigray this was achieved; however, in other regions, particularly those with relatively low HIV-prevalence and a high percentage of antenatal care provided at health post level where HIV testing is largely unavailable, an integrated campaign-like outreach proved to be more efficient (SNNP, Oromiya). In total, the CPMTCT Project tested 13,077 pregnant women through outreach, of whom 50 tested HIV-postive and were linked to nearby ART HCs. In 11 woredas in Amhara and 2 in Tigray, the regions are piloting HEW counseling and testing of antenatal care clients (and others). In total, 121 mothers were tested by HEWs (none tested HIV-positive).

A total of 482 outreaches to health posts were supported, mostly in quarter four. Even though the outreach occurred largely in the "high" prevalence woredas, the positivity rate was very low: 0.2% (2 in 1,000) in SNNP; 0.6% in Amhara; 0.3% in Oromiya; and 1.5% in Tigray.

Table 3 : Regional disaggregation of outreach achievements of selected MNCH/PMTCT indicators

S.No.	Performance indicators	Regional disaggregation					# of clients served
		Amhara	AA	SNNP	Oromiya	Tigray	
1	# of new antenatal care clients	1,968	8	8,978	867	1,268	13,089
2	# of pregnant women with known HIV status	1,965	8	8,969	867	1,268	13,077
3	# of HIV-positive pregnant women identified	11	0	17	3	19	50
4	# of pregnant women referred/linked/ to ART HCs	11	0	17	3	19	50
5	# of male partners of pregnant women tested	430	0	489	99	164	1,182

d*) MSGs*

Mother to mother support groups have proven to be an effective method of securing adherence and one that shifts the training and follow-up burden from health professionals to mothers themselves. The FMOH/HAPCO demonstrated their commitment to this intervention by funding MSG expansion through the Global Fund. At both the health center and community level, MSG members comply with recommended PMTCT behaviors; however, a certain number of HIV-positive mothers are needed before a group can be started, and the commitment of the site coordinator is crucial for survival of the MSG. For example, of the 83 MSG mothers who delivered in the reporting period, all but three delivered at the HC; all are on ART or received ARV prophylaxis; 140 of the 145 mothers with babies under six months reported exclusive breastfeeding; and 59 of the 67 infants between 45 days and 2 months of age had received OI prophylaxis.

Table 4: MSG indicator chart for PMTCT-related performance at project-supported MSGs

Selected MSG Indictors		Community MSG	Facility MSG	Total
# MSG sites supported		107	8	115
# newly enrolled to MSG	HIV-positive pregnant women	193	46	239
	HIV-positive non-pregnant women	310	179	489
# newly enrolled MSG members on pre-ART or ART	Pre-ART	14	35	49
	ART	128	144	272
# MSG members who received material Care & Support	Food	43	5	48
	IGA	5	0	5
# MSG members who delivered	At HC/hospital	63	17	80
	At home	2	1	3
# MSG members who received ARV prophylaxis	sdNVP/combined	41	11	52
	on ART	30	6	36
# infants born to MSG members and who received ARV prophylaxis		61	20	81
# MSG members with infants < 6 months old		108	37	145
# MSG members with infants < 6 months old and practicing Exclusive Breast Feeding		104	36	140
# infants of MSG members 45 days to 2 months of age		55	12	67
# infants of MSG members 45 days to 2 months who started Cotrimoxazole		45	12	57
# partners of MSG members disclosed to partners		102	63	165

The CPMTCT Project provided technical and financial support for the National MSG TOT in October 2009. Participants were then to train and help establish health center-level MSGs using Global Fund monies. We repeated the TOT in SNNP as some of the previously trained trainers were no longer present in the region. A total of 39 health sector staff members were trained as trainers. In addition, the project provided technical support to train 231 site coordinators and mother mentors for the RHB, HCSP, and people living with HIV/AIDS organizations working in Addis Ababa, Amhara, and SNNPR.

In addition to mentoring and providing registers and referral cards for the 99 MSGs at Addis Ababa sites that were established by the AARHB with Global Fund monies, the project established eight expansion HCs and eight community MSGs outside of Addis Ababa. Lessons learned under the Capacity Project guided the timing of establishing MSGs at the health facility-level: we first established solid PMTCT services and waited until at least six HIV-positive pregnant mothers had been identified at the facility.

While still new, initial experiences with CMSGs have shown that they are successful only if there is consistent and firm support from the public health sector. For example, in Addis Ababa only about half of the 99 CMSG sites are successful. The CPMTCT Project assisted the RHB in assessing their CMSG program and scale-up strategy. Given that MSGs exist at the hospital- and HC-level, CMSGs are not needed in every kebele. In the coming year, the project will support the stronger sites in six Addis Ababa sub-cities with a view to assisting the sub-city to replicate in other kebeles in the sub-city as appropriate as well as within our HC catchment area if needed.

In addition, an assessment on the gaps on infant feeding practices was conducted by the CPMTC project in Tigray and Addis Ababa, and the results were shared with ministry staff, United States Government partners and TWG members. The assessment found variable understanding of FMOH/HAPCO guidance around infant feeding for HIV-exposed infants among HC providers and MSG mothers, as well as infants becoming malnourished after abrupt cessation of breastfeeding at six months. Based on the identified gaps, training on infant feeding and nutrition was organized by the project for MSG officers and RHB staff.

e) Referral

The CPMTCT Project trained health extension program (HEP) supervisors and MNCH focal persons as trainers to train UHEPs, HEWs and VCHWs in antenatal care ANC/CPMTCT demand creation and referral and supplied them with referral cards. This activity took place in the last two quarters of the year as there were some delays getting the referral cards out and translated.

Review meetings are a key part of the performance improvement cycle where performance is analyzed, including referral uptake data, causes for gaps identified, and action plans developed to address these causes. However, the changing context of the primary health care unit- (PHCU) versus woreda-level review/planning complicated rollout. Under the Capacity Project, the community intervention trained and mentored the woreda-level HAPCO focal person or the woreda-based HEW supervisor to collect the referral cards and facilitate the review/planning meetings. However the catchment area was that of an IntraHealth-supported HC and the five attached health posts and corresponding kebeles. The situation on the ground has now changed with the promotion of the PHCUs that consist of one HC and five health posts for each 25,000 population, and on average four HCs per woreda. Each HC is supposed to have a health extension program supervisor, although this is still in process. In addition, in rolling out the referral in urban areas, the wide selection of health facilities (HCs, hospitals, private and faith-based clinics) is also a complicating factor. In fact, the CPMTCT Project held meetings after the training of UHEPs/HEWs/VCHWs had been completed with all representatives from all health facilities and town/woredas offices to present the referral system and role of each stakeholder.

The CPMTCT Project and the RHB have reflected on the issue of bi-directional referral at lower levels. It is not reasonable for HCs to refer women back down to the HEW-level if the only reason is simply to inform the HEW rather than to receive a needed service. Rather, the HEW/UHEP will need to follow up on referred women themselves during house-to-house visits or ask a VCHW to do so. For example, CMSG mothers will visit UHEP-identified pregnant mothers to see if they took up referral to the HC for antenatal care/PMTCT. Since the number of HIV-positive pregnant women/HIV-positive mothers with infants under 2 in a UHEP's or HEW's catchment area is unlikely to be more than 2-4, it seems reasonable to ask UHEPs/HEWs to follow up directly on these cases.

Community resource mapping was completed for all 60 woredas and shared for woreda-based planning. Also PATH shared its list of CSO partners by region with a view to MSG referral to PATH Strengthening Community Responses to HIV and AIDS project (SCR) partners. At the time of community resource mapping, the MSGs had not been established nor had the PATH partners begun project activities. However, explicit cross-referral strategies for MSG mothers and PATH SCR beneficiaries have been identified at the national level and follow-up at the regional level is planned for year two. The CPMTCT Project will also contact the partner awarded the new OVC RFA PEPFAR-funded initiative to establish cross-referral linkages, especially as the new RFA foresees support to the infant and pre-school age group.

f) Drafting a protocol to pilot transport allowances for health extension program supervisors

Piloting transport allowances for UHEP and HEW supervisors: a protocol for the pilot has been drafted in consultation with the Tigray RHB, which will be finalized in November 2010 when the IntraHealth Director of M&E Laura Gibney travels to Ethiopia to provide M&E support to the in-country M&E team.

Table 5: Actual performance vs. planned targets for activities under objective 2

Indicator #	Performance Indicator	Actual	Target	Accomplishment (%)	Reason for variations
2.0.1	# of new antenatal care clients	171,653	139,318	123.2	Actual data includes all project supported towns and woredas and reflects a real increase in ANC demand.
2.0-2	# of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	29,113	101,666	28.6	In order to avoid double counting with HCSP, the actual report is based only on data from expansion HCs, indirect HCs, and outreach activities while the target was set for all intervention woredas including those where HCSP is active at the HC-level. These latter we call overlapping woredas.
2.0-3	# of HIV- positive pregnant women identified in the reporting period	262	3,143	8.3	Low HIV prevalence in some of the expansion HCs. Further, the target included results from overlapping (high-prevalence) woredas which we are not able to count.
2.0-4	# of HIV- positive pregnant women who received ARV drugs to reduce risk of MTCT	67	2,339	2.9	During the early months of expansion, most of the expansion HCs was referring HIV-positive PW to ART HCs and hospitals (AA). And there has been a lack of ARV supplies at HCs.
2.0-5	# of newborns born to HIV-positive mothers who received ARV prophylaxis	41	1,850	2.2	For the same reasons stated in 2.0-4
2.0 -6	# of infants receiving Cotrimoxizole (CTX) prophylaxis	23	1,850	1.2	For the same reasons stated in 2.0-4
2.0 - 7	# of children born to HIV-positive mothers and tested for HIV at 18 months	-	1,850	-	Too early to report this data for expansion HCs.
2.0 - 8	# of deliveries attended by a skilled birth attendant	36,096	49,871	72.4	Actual data was collected until August 2010. Also the target included overlapping woredas which we cannot report on.
2.0 - 9	# of deliveries for HIV-positive women by skilled birth attendant	43	1,675	2.6	This information is only for expansion HCs directly supported by IHI. The HMIS summary didn't capture these data for indirect HCs.
2.1 - 1	# of health facilities providing antenatal care services that provide both HIV testing and ARVs for PMTCT on site	48	46	104.3	Direct HC expansion sites
2.1 - 2	# of health posts providing PMTCT/MNCH services	477	200	238.5	This refers to health posts that participated in counseling and testing during outreach and linked HIV-positive pregnant women to ART sites.

Indicator #	Performance Indicator	Actual	Target	Accomplishment (%)	Reason for variations
2.1 - 3	# of health care workers who successfully completed an in-service training program within the reporting period	6,402	3,800	168.5	Under-estimated training needs, especially for indirect sites and UHEP which largely explains the overachievement in training.
2.1 - 4	# of PMTCT service providers trained in effective referral/ follow-up of mother-baby pairs	2,771	1,500	184.7	For the same reasons stated in 2.1-3
2.2 - 2	# of MSG site coordinators/mentor mothers who have received MSG training	158 (231)	400	97.3	We did not collect TIMS for 231 trainees as the project provided technical support (trainers) but not financial support for the trainings.
2.2 - 3	# of MSG sites supported	115	60	191.7	When setting the targets, we had assumed that at least 30-35 of the 99 proposed CMSGs for Addis would fail to be established. However, 99 sites were established and received supervision, even if, as expected, a large number have failed to thrive.
2.3 - 1	# of woredas with service mapping completed of referral sites in the community	60	50	120.0	
2.3 - 2	# of MOUs produced with different service delivery sites on referral linkages	0	15	-	Late start of community mobilization and referral linkage activities.
2.4 - 1	# of tools/systems introduced for confirming client follow-up of referrals	2	1	200.0	Referral card and baby mother follow-up forms
2.5 - 2	# of HIV-positive women counseled on family planning	123	3,143	3.9	For the same reasons stated 2.0-2
2.6 - 1	# of community-facility MNCH oversight committees established	0	10	-	Used existing committees

Objective 3: Increase demand through community outreach

The demand creation strategies include production of IEC/BCC training materials and job aids, awareness-raising through mass media and community conversation, creating an enabling environment through involving local leaders, and interpersonal communication through small group discussion and household visits to promote behavior change (referral and uptake of referral for MNCH/PMTCT services). As always, the performance improvement approach of training, supportive supervision and mentoring, review/planning meetings and refresher training apply.

Activities under this objective included;

a) Materials development: HEW/VCHW training manual; specially adapted training manual and materials for Ethiopian Orthodox Church volunteers, both for MNCH/PMTCT demand creation and couples counseling.
b) Awareness-raising: initial community sensitization meetings, community conversations
c) BCC: HEW supervisor and MNCH focal person trainings in MNCH-PMTCT Behavioral Change /Community Mobilization TOT; training of VCHWs/HEWs, including spiritual fathers
d) Review meetings at the woreda- and PHCU-level (see objective 2)
e) Assisting IFHP to update its peer education training materials and HC-level checklists to include PMTCT
f) Pilot protocol for layette incentive kit for institutional delivery.

Implementation of objective three activities was delayed for a number of reasons beyond our control: the resignation of the national DCCM coordinator for medical reasons, difficulties concluding an agreement with EOC-IOCC, and the temporary closure of the Pathfinder office. However, through a tremendous effort, most workplan activities under this objective were completed this year, albeit later in the year than planned.

Materials
Materials produced this year include:
a) Adaptation of existing training materials for TOT and basic MNCH/PMTCTC demand creation for IOCC staff and EOC-DICAC volunteers
b) HEW/VCHW training manual for MNCH/PMTCT demand creation. In addition interpersonal communication job aids for HEWs and VCHWs are under production and should be ready in the first quarter of FY 2011.

Awareness raising
In addition to the PMTCT radio spots produced for the safe motherhood month, the project aired PMTCT radio programs in Amharic, Tigrigna, and Oromiffa and trained 27 media staff on PMTCT. The project also held woreda-level sensitization meetings for over 3,000 local leaders and health extension, health facility and health office staff to secure buy-in and support for demand creation efforts in their woredas. In some regions, kebele-level community conversations were used for the same purpose.

BCC and referral
Fifty-nine woreda MNCH focal persons in Amhara and Tigray were trained as trainers in MNCH/PMTCT demand creation, and subsequently trained 1,851 HEWs, VCHWs, and their supervisors, in addition to 341 spiritual fathers and volunteers in behavior change and community mobilization to create demand at the HC-level for MNHC/PMTCT services, including male partner testing in antenatal care.

In Amhara and Tigray, 108 spiritual fathers were trained in the importance of male involvement and agreed to promote couples counseling, partner testing, and especially encourage men to assume shared responsibility for HIV-free survival of exposed infants.

Some 3,871 clients were referred during small group discussions and house-to-house visits; of those clients, 1,572 received MNCH/PMTCT services at HCs as per the referral. As explained under objective 2, there were problems informing and educating all the concerned stakeholders about the referral system and cards. As a result some health care providers gave the referral cards back to patients or threw them away.

IFHP-CPMTCT cooperation
The CPMTCT Project leveraged IFHP administrative and logistics personnel to facilitate payments of per diems for demand creation trainings, shared costs for short-term technical assistance, and shared resources like the audio-enabled mobile vans. The CPMTCT Project helped IFHP incorporate PMTCT topics into its peer education program and assisted IFHP to update its HC checklist to include HIV test kits and ARV supplies.

Pilot protocol for institutional delivery
The outline of the protocol has been agreed to with the Tigray RHB. Finalization of the operations research protocol and data collection tools will be completed during the November short-term technical assistance visit of the IntraHealth M&E Director Dr. Laura Gibney.

Table 6: Actual performance vs. planned target for activities under objective 3

Indicator #	Performance Indicator	Actual	Target	Accomplishment (%)	Reason for variations
3.1 - 2	# of evidence-based best practices recognized by expert body in country	1	1	100.0	
3.2 - 1	# of the targeted population reached with individual and/or small group-level preventive interventions that are based on evidence and/or meet the minimum standards required	53,779	21,000	256.1	Under-targeted for the year especially for # of people reached through small group discussions by IOCC volunteers.

3.2 - 2	# of IEC/BCC materials produced or adapted which primarily focus on PMTCT	1	2	50.0	Delayed because message harmonization efforts by the FMOH, C-Change and others not accomplished as originally planned. The production of IEC materials has begun and will be shared with those leading harmonization efforts.
3.2 - 3	# of IEC/BCC materials distributed at community level	2,636	1,500	175.7	Under-targeted for the year
3.2 - 4	# of referrals from community-based and health post workers acted on by clients attending antenatal care/PMTCT services	1,572	13,932	11.3	Delay in printing referral cards, late start of referral activities by volunteers and HEWs, and coordination problems at facility level
3.2 - 5	# of community volunteers trained in PMTCT	2,251	500	450.2	This includes both HEWs and VCHWs as the TIMS forms were not filled separately for the two groups.
3.5 - 1	# of male partners of pregnant women who are counseled and tested for HIV, and who received their results	3,301	20,333	16.2	Target includes overlapping woredas but the actual is only from expansion HCs, indirect HCs, and outreach activities
3.5 - 2	# of clergy and other volunteers trained on how to promote positive male engagement in MNCH/PMTCT	108	150	72.0	

Objective 4: Improve quality

Project activities under this objective included the development of supportive supervision checklists, HMIS TOT and cascade training, PI and SS TOT and cascade training, participation in joint SS, follow-up mentoring in new PMTCT HC sites, and revision of AA region joint SS HIV checklists to include more MNCH items. IntraHealth central office advisors and managers also supervised all regional CPMTCT programs during this period.

Tools

The CPMTCT Project piloted a revised MSG register which was adopted for use within its program and shared this version with other partners supporting MSGs as at this stage all partners have adapted the original register. The project revised and shared its MNCH/PMTCT SS checklist with the FMOH (and indeed with our program in Rwanda where it has been adapted by the FMOH there) and updated the MSG and DCCM SS checklists and monthly summaries. The checklists are based on standards (MNCH/PMTCT) and recognized practices (DCCM/MSG) and data that allow users to assess performance against standards or targets. These tools are used in the PI and SS training. In Addis Ababa region, CPMTCT staff helped the region revise their integrated HIV supportive supervision checklist to include more MNCH/PMTCT elements.

As part of the Quality Management TWG, the CPMTCT Project shared its PI tools and participated in drafting a standard operations protocol for the quality management framework. However, due to changes within the FMOH medical directorate, the Quality Management TWG was dormant in the latter half of the year.

Performance improvement and supportive supervision:

Thirty-seven IntraHealth CPMTCT staff and 93 woreda, zone, and regional health staff members were trained as trainers in PI and SS; these trainees in turn trained 193 health center managers and providers. In October, Oromiya region is using its own TOT-trained staff to train 28 zones and woreda health office staff in PI and SS using the CPMTCT checklists to expand PMTCT into new HCs throughout the region. The Oromiya RHB is paying the trainees per diem out of its own funds while asking IntraHealth to share only venue and trainers' per diems. However, in other regions it wasn't always possible to count on the TOT-trained RHB staff as trainers, in part due to other work priorities since these trainings hadn't been included in the regions' annual work plan for Ethiopian Fiscal Year 2002.

Joint supportive supervision and follow-up mentoring: HC level
The CPMTCT Project facilitated joint SS in 48 of its expansion HCs and participated in the bi-annual integrated HIV supervision in Oromiya and Amhara regions.

In woredas with one direct expansion site but other new HCs into which the woreda sought to expand PMTCT services, IntraHealth assisted in training providers at the new HCs (indirect sites) and procuring job aids and minimum infection prevention supplies. The project trained zone, woreda health office and/or new HC managers in the PI and SS system to help the woreda expand the services but would only participate in quarterly joint SS at these sites.

MSGs
The AARHB had secured Global Fund (GF) monies to create community mother support groups at the kebele level in 99 kebeles in Addis. At the request of the AARHB, the CPMTCT Project agreed to mentor kebele-based CMSG mentor mothers-PMTCT focal persons and their supervisors to complement the support for training, stipends, and coffee the AARHB secured through the GF. AA staff supervised all 99 kebeles, provided registers and referral cards for mentor mothers, and assisted the AARHB in assessing their CMSG strategy.

Table 7: Actual performance vs. planned target for activities under objective 4

Indicator #	Performance Indicator	Actual	Target	Accomplishment (%)	Reason for variations
4.0 - 1	% service delivery sites (HCs, community provider sites) with acceptable data quality standards		80%	-	Postponed to year 2
4.0 - 2	Projects' data quality control system implemented in project-supported sites		1	-	Postponed to year 2
4.2 - 1	# of HC managers and providers trained in PMTCT quality improvement/PI	193	165	117.0	
4.3 - 1	# GOE personnel trained in PI/SS (not HC managers)	93	95	97.9	
4.3 - 2	# of service sites receiving SS regularly	48	95	50.5	Because of the delay in kick-off UHEP activities, the SS was done only at 48 expansion HCs.
4.3 - 3	# of MSGs receiving SS regularly	115	60	191.7	The target assumption was that only 60 or so CMSG groups would be established even though the AARHB plan was 99. Ninety-nine groups were established and so received supervision but some failed through lack of members, or lack of direction and support from kebele staff.
4.4 - 1	# of follow-up visits for mentoring PMTCT service providers	140	184	76.1	September follow-up SS is not included.
4.5 - 1	# of new quality improvement-related resource materials (guidelines, job aids and MNCH/PMTCT integration tools) approved/implemented for first time	3	1	300.0	This reflects the revised integrated checklists.
4.5 - 2	# of health facilities with quality improvement tools	48	46	104.3	
4.6 - 1	# of woreda health offices (WrHOs) using HMIS data to assess performance during review meetings	59	40	147.5	Project supported more review meetings at woreda level that focused on this element.

7. Challenges and Constraints and plans to overcome them during the reporting period

Annual challenges and Constraints for each program area

UHEP: In most regions, the UHEPs have just completed their baseline data collection; supervisors are still being trained in some areas, and only a few UHEPs have begun counseling and testing activities, even though this has been confirmed as a priority activity at FMOH and RHB levels. UHEP attachment to a PHCU is clear in Tigray, Amhara, and SNNP, but in Addis Ababa and Oromiya they are still officially attached to kebeles which complicates referrals, and in Oromiya this means that their supervisors are mostly environmental sanitation graduates.

Widespread test kit shortages; ARV prophylaxis shortages at some sites, general lack of OI drugs, regional differences in Dry Blood Sample rules: The consequences of this are: lower than planned achievement for antenatal care testing and ARV prophylaxis, and less DBS testing of HEI.

HC services initiated without adequate supplies: Many new expansion sites had no or limited basic infection prevention supplies and no revolving funds with which to procure items.

HMIS: Except in SNNP, and to some extent in Tigray, the HMIS rollout has been greatly delayed as RHBs do not have the budgets to hire the required staff, nor shelving and minimal furniture for the chart rooms. Additionally, different HCs in the same woreda are using different versions of the HMIS which is complicating aggregation and no doubt adversely affecting data quality.

Delays in message harmonization workshop: This delayed the production of IEC/BCC materials to the point that the CPMTCT Project agreed with C-MNCH TWG to go ahead with producing materials for immediate use and submit to a wider group as part of the harmonization exercise.

Timing/coordination of training of referral volunteers and monthly PHCU review/planning meetings and quarterly woreda review/planning meetings. In some cases the volunteers began referring before HCs were oriented on accepting referral cards or HEP/HEW supervisors in leading the review/referral meetings.

Plans to overcome challenges and constraints in each of your program areas

UHEP: The CPMTCT Project is working closely with the UHEP working groups at the RHB-level as well as with the town administrations to ensure referral and follow-up of MNCH/PMTCT clients, and to provide house-to-house counseling and testing when kits are available. In Addis Ababa, we are participating in the definition of both monitoring tools for UHEPs and their supervisors, and defining the UHEP attachment to HCs.

Supplies: The CPMTCT Project has ensured that RHBs have submitted relevant details of the new HCs, (all should provide PMTCT services) to PFSA. In addition once the CPMTCT expansion sites are finalized, IntraHealth will also submit to USAID and SCM to assure these sites are on the procurement and distribution lists. In year two, the CPMTCT Project will agree with regional PFSA/SCM offices on their role in funding training and supervising/mentoring for project HC and woreda managers.

HMIS: The CPMTCT Project will continue to participate in regional HMIS working groups and support training, supervision, and mentoring of HC and woreda staff.

Timing and coordination: This issue has been resolved where it occurred and will be avoided in the future as the orientation of PHCU and woreda staff will come before training of volunteers. The project is developing step-by-step implementation guidance for staff.

8. Data Quality issues during the reporting period

Specific concerns you have with the quality of the data for program areas reported in this report IntraHealth's M&E team conducted visits to the regions (Tigray and SNNPR) to verify some of the baseline data and make appropriate corrections, as well as to supervise our M&E staff, clarify M&E issues, etc. The project aims to train and mentor WrHOs to improve the quality of data. Currently the quality of data is not high at woredas (as our staff discovered when they compared data collected at woreda offices with data collected from the facilities themselves); hence, some data collected at the woreda level may not be correct. In the course of the baseline we discovered different interpretation of the same indicator among woreda staff. This is a concern in the FMOH and will be a key focus in the HMIS strengthening strategy.
What you are doing on a routine basis to ensure that your data is high quality for each program area The CPMTCT service delivery officers regularly conduct SS visits to sites during which they examine data quality, amongst other things. Where problems exist they address them with facility staff. In addition, the M&E team at the project's central office and regional offices reviews the data submitted by service delivery officers and addresses any problems with the data. Any time there is missing data from the HC- or woreda-level, staff returns to collect the data and update records in time for reports to the funder. This was a problem in the past when the PEPFAR and FMOH reporting dates did not coincide; however, this issue is resolved for the coming year. In addition to the regular SS visits during which data is reviewed with HC staff, the project supported review meetings where MNCH/PMTCT data is analysed and used for decision making in 59 woredas and also supports selective training at regional and woreda levels with partners working in HMIS.
How you planned to address those concerns / improve the quality of your data for each program area As the HMIS training is rolled out, the CPMTCT Project staff will play a greater role in providing supportive supervision and mentoring to woreda- and facility-level staff on data quality assurance and analysis. SNNP has already begun this process, in coordination with the regional HMIS TWG.

9. Major Activities planned in the next reporting period

Upcoming activities should highlight planned activities and solutions to identified constraints (write for each program area)

- Submission of the annual project report, and year two workplan and budgets; extension of sub-awards with partners
- Finalization of M&E operational plan; finalizing operations research protocols and data collection tools
- Expansion site selection (assessment, selection, and MOU with RHB)
- Finalization of national MNCH/PMTCT training: piloting and final revision
- Training: staff training in infant feeding and "Helping Babies Breathe;" health-sector staff training in HMIS, PI and SS, and MNCH/PMTCT; MSG training for site coordinator and mentor mother training
- SS/mentoring to HCs (PHCU), woredas, and mother support groups
- Facilitating PHCU and woreda MNCH/PMTCT review/planning meetings
- Participating in FMOH and RHB/RHAPCO annual review meetings; preparation of safe motherhood month activities
- With the World Bank, UNFPA, UNICEF, WHO partners, the FMOH, and the RHB, defining CPMTCT BEmOC activities to ensure no overlap and adequate supervision and mentoring of newly (re)trained health center level providers
- Logisitcs strengthening activities in year two defined for each region, so no overlapping
- Transition criteria established from intensive to less-intensive support finalized and agreed with FMOH and the RHB.

10. Environmental compliance

Describe any issues related to environmental compliance (if there are any)

IntraHealth-Ethiopia program agreed with the mission to develop an environmental management and mitigation plan for CPMTCT at the end of August 2010. Accordingly, we have developed a clear environmental management and mitigation plan and distributed the same to regional offices. We will collect data on the environmental management and mitigation plan during year two implementation from CPMTCT sites and will purchase the required equipments for the same.

11. Issues requiring the attention of USAID Management

Identify and state issues that USAID needs to look at and address for each program area

- Continue to include IntraHealth in relevant USAID-led PMTCT supply meetings
- Please keep implementing partners abreast of any knowledge of government plans with respect to NGO provident funds.

12. Data Sharing with Host Government:

Have you shared this report with the host government?

Yes ☐
No ☒

If yes, to which governmental office/s?

[Please put your response here]

If No, why not?

We will send the report to FMOH HPDP and share it with the RHBs after sending it to USAID for review.

13. Appendices

(Include any relevant documents, data etc as appendices)